IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

February 6, 2008

Anna Ong, Administrator
Beehive Home Maryland-Assisted Living Center, LLC
5521 W Hollilynn Dr
Boise, ID 83709

License #: RC-884

Dear Ms. Ong:

On January 4, 2008, a State Licensure survey was conducted at Beehive Home Maryland-Assisted Living Centers, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Karen McDannel, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

KAREN MCDANNEL, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

January 10, 2008

Anna Ong, Administrator
Beehive Home Maryland
5521 W Hollilynn Dr
Boise, ID 83709

Dear Ms. Ong:

On January 4, 2008, a State Licensure survey was conducted at Beehive Home Maryland-Assisted Living Centers, Inc. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by February 4, 2008.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Community Care Program

JS/sc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R884	A. BUILDING _____ B. WING _____	01/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOME MARYLAND-ASSISTED LIVIN(	612 E MARYLAND NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the initial survey conducted at your facility. The surveyors conducting the initial survey were: Karen McDannel, R.N. Team Coordinator Health Facility Surveyor Polly Watt Geier, MSW Health Facility Surveyor	R 000		

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Beehive Maryland	612 E Maryland	353-9839
Administrator	**City**	**ZIP Code**
Anna Ong	Nampa	83686
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDaniel	IS	1-4-08

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	.210	The facility did not provide individualized (or) group activities that were sufficient to meet all residents needs.	1/4/08	Km
2	305.01	The facility RN did not complete an initial assessment of residents use of side rails in rooms 3, 7 & 10.	1/8/08	Km
3	305.02	The facility RN did not ensure the PRNs as ordered by the physician were available in the facility.	1/24/08	Km
4	335.03	Staff were not observed to consistantley change gloves or wash hands during meal prep and between resident cares.	1/30/08	Km
5	625.03d	The facility staff were not orientated or trained to provide resident #1 with a 2 person transfer.	1/30/08	Km

Response Required Date	Signature of Facility Representative	Date Signed
2-4-08	Anna M Ong	1/4/08